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### **RELEVANCE OF THE CAHPS® CONSUMER ASSESSMENT SURVEY FOR WORKERS COMPENSATION MEDICAL CARE**

Presented at the May 1, 2003 Research Colloquium on  
Workers' Compensation Medical Benefit Delivery and Return-to-Work

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The quality of medical care provided to individuals for work-related illnesses or injuries is important not only to employers and state programs, but also to the workers receiving the care. Workers' confidence in and satisfaction with workers' compensation care will influence their attitudes about the quality of the coverage offered by their employers as well as the performance of the larger workers' compensation system. In this context, it is important for providers, employers, and state officials to have information about the experiences that individuals had with workers' compensation medical care and their judgments about the quality of that care.

Feedback from consumers about the quality of their health care complements other measures of the technical quality of clinical care. For example, substantial work has been done on the development of indicators defining appropriate practices for surgical procedures, use of prescription medications for specific health conditions, or management of a chronic disease such as diabetes. However, all of these clinical procedures could be performed perfectly while still leaving the patient unsatisfied, if the provider has not effectively engaged the patient in the care process and provided the care in a prompt and respectful manner.

This paper explores the potential applicability of one health care survey and reporting system to worker's compensation medical care. This system is the Consumer Assessment of Health Plans (CAHPS®), which was developed by a consortium of research organizations in collaboration with the federal Agency for Healthcare Research and Quality (AHRQ, previously named the Agency for Health Care Policy and Research) (Crofton, et al., 1999). CAHPS has been used across the country by large employers, Medicare, Medicaid programs, states as employers, and other sponsors to obtain information from their constituencies about their experiences with health insurance plans and the health care and related services they received. The National Committee for Quality Assurance also uses CAHPS in its accreditation of managed care health plans. The CAHPS survey and reporting methods, which have been developed and tested over many years, could be a useful resource for application to the worker's compensation environment.

### **OVERVIEW OF CAHPS®**

As buyers of health care have striven to get more value for their money, they have demanded better information to help them compare and evaluate the performance of health plans. Because the experiences and satisfaction of the people enrolled in a plan are important indications of performance, numerous employers, government agencies, accreditation bodies, consumer groups, and health plans have moved to develop and implement consumer surveys.

To interpret the consumer ratings of a given health plan most effectively, these ratings need to be compared to the same ratings for other plans. In response to this need, AHRQ initiated CAHPS to develop and evaluate a standard comparative survey and reporting

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methodology for use in a wide variety of applications and settings across the country. AHRQ issued cooperative agreements in 1995 with RAND, Harvard University, the Research Triangle Institute, and Westat to collaborate in this effort. The five-year research and development project was designed in two phases with four objectives:

*Phase 1: Design, development, and testing of surveys and reporting methods*

1. Produce reliable, valid, and rigorously tested survey protocols for collecting information from consumers regarding their assessment of health plans and services.
2. Develop and test the effectiveness of different formats for conveying the resulting information to consumers.

*Phase 2: Demonstration of survey and reporting implementation and effects*

3. Demonstrate the resulting survey protocols and reporting formats in real world settings, and provide feedback for future revisions.
4. Evaluate the usefulness of consumer survey results to consumers, and purchasers acting on their behalf, in making informed selections of health care plans and services.

It is important to make it clear that the CAHPS survey is NOT a consumer satisfaction survey per se—there are no questions that ask respondents how satisfied they are with some aspect of their care. The CAHPS survey measures health plan performance using (1) global ratings (i.e., ratings of primary doctor or nurse, health plan) and (2) consumer reports of their experiences with using a health plan (i.e., getting needed care, getting care without long waits, how well doctors communicate, treated with courtesy and respect by office staff, and health plan customer service). The ratings are individual items using 0-10 response scales. The reports of experiences are composite scores that are averages of responses to sets of individual items using three-category or four-category response options (AHRQ, 1999).

There are several different CAHPS survey questionnaires—for individuals in commercial plans, Medicare, Medicaid recipients, and other specific population groups. Each survey questionnaire consists of a set of core items that is used on all surveys plus other items specific to the population for which the survey is fielded. Within each enrollee group (e.g., commercial, Medicaid) there are separate questionnaires for adult and child respondents (with a parent or guardian responding for the child). The CAHPS questionnaires are on the AHRQ web site at [www.ahrq.gov/qual/cahps/cahpques.htm](http://www.ahrq.gov/qual/cahps/cahpques.htm) and information on the survey and reporting kit is on the CAHPS Survey Users Network web site at [www.cahps-sun.org/home/index.asp](http://www.cahps-sun.org/home/index.asp).

The core items consist of the items for rating the primary provider and health plan, plus the items used to calculate the composite scores for reports of experiences with the health plan. The CAHPS 1.0 survey and report had four rating items and seven report composites. The number was reduced to two ratings and five composites for CAHPS 2.0 in response to findings that consumers were confused by too much information (See Appendix A). Both the choice of topic areas and the specific items used in the CAHPS survey have been tested extensively by the CAHPS consortium (Harris-Kojetin, et al., 1999; Hays, et al., 1999; Brown, et al., 1999; Fowler, et al., 1999; Marshall, et al., 2001; Zhan, et al., 2002; Zaslavsky, et al., 2002). The survey continues to be tested as it evolves.

A basic feature of the CAHPS survey design is that the respondent is asked to think about all the care they received over a specified time period when they respond to questions in the

survey. Initially, the recall period was twelve months. The recall period was shortened to six months for the Medicaid survey because many beneficiaries were not on Medicaid for a full year. Medicare also adopted a six-month recall period because respondents had trouble remembering care obtained longer than six months ago. The commercial plan surveys continue to use a twelve-month recall period.

The CAHPS report template uses two formats to present survey results. *Star measures* summarize relative plan performance, and *bar graphs* summarize absolute performance. For the star measures, two stars are shown for plans with survey results that are not significantly different from the average for all other Medicaid plans in the state; one star for plans that scored significantly lower than average, and three stars for plans that scored significantly higher than average. Sponsors of the CAHPS survey (e.g., employers, Medicaid programs) have differed in how they use the stars or bars in reporting CAHPS results. Some have used both the stars and bars, others have chosen to present only the star measures, and a few have used only the bars. Refer to Figures 1 and 2 for examples of each reporting format. Figure 1 shows a star table used by the New Jersey Medicaid program, and Figure 2 shows bar charts used by the Iowa Medicaid program.

## **CONSUMER USE OF PLAN PERFORMANCE INFORMATION**

Research on consumer health plan choice has shown that many factors play an important role in plan choices, including the services covered, premiums and out-of-pocket costs to the consumer, maintaining established relationships with providers, and freedom of provider choice (Mechanic, et al., 1990; Marquis and Rogowski, 1991; Davis, et al., 1995; Scanlon, et al., 1997, Sainfort and Booske, 1996; Gibbs, et al., 1996; Tumlinson, et al., 1997). Although there is some evidence that consumers are likely to consider information about plan performance when it is available, the empirical evidence is mixed about how they use it and its relative importance in their decision-making (Scanlon et al., 1997; Marshall, et al., 2000).

When making health plan choices, consumers seem to give a lower priority to considerations of quality and service than to the scope of coverage, provider choice, or premium costs (Sainfort and Booske, 1996; Castles, et al., 1997; Knutson, et al., 1997; Robinson and Brodie, 1997; Tumlinson et al., 1997; Chernew and Scanlon, 1998). However, Sainfort and Booske (1996) found that consumers' use of plan performance information tends to increase as their exposure to the information increases and they learn how to interpret it. Recent studies also have found that consumers are more likely to use performance information to avoid low rated health plans, which is consistent with the decision making science that consumers tend to make decisions more to avoid risk than to achieve gain (Hibbard et al., 2000; Scanlon et al., 2002).

The CAHPS field demonstrations were performed to extend our knowledge of consumer use of plan performance information. The demonstrations (1) assessed consumers' reactions to the CAHPS information and reports, (2) tested the extent to which having CAHPS information affected the plan choices consumers made, and (3) refined the CAHPS products based on feedback from users.

Evaluating the effect of CAHPS reports on health plan choices is analogous to evaluating the effectiveness of a clinical intervention. The *effectiveness* of a clinical intervention depends on its *efficacy* in the treated population and *the proportion of the target population reached* for treatment. Various factors determine the effectiveness of CAHPS in informing consumers' health plan choices, including how much consumers pay attention to the health plan performance

information, whether and how they weigh differences among plans in making their choices, and which plans they ultimately choose. All three of these behaviors are influenced by the characteristics, preferences, and attitudes of different consumers; by the characteristics of health plan options available to them; and by the costs and benefits of acquiring different types of information. Moreover, there is a feedback loop between selection behavior and ultimate attitudes about the plan options—the very act of gathering and considering information, and weighing available options, is likely to change a consumer’s attitudes.

## **WHAT WE HAVE LEARNED FROM CAHPS**

The demonstrations performed by RAND, Harvard, and RTI provided rich information on the reactions of sponsors, health plans, and consumers to both the CAHPS survey and the reports presenting comparative information on health plan performance on CAHPS. Some highlights of these findings are presented here.

### **The CAHPS Survey**

A fundamental issue to be tested was the extent to which the CAHPS survey discriminates among health plans on the various ratings and report composite measures. The CAHPS demonstrations found significant variation among health plans on the CAHPS measures (Solomon, et al., 2002; Short, et al., 2002; Farley, et al., 2002a). In some applications, few differences among plans were found. We were confident in interpreting these as valid results, given that differences indeed had been found in many diverse settings and sets of health plan choices.

Feedback from the demonstrations indicated that the CAHPS survey covers the topics that are most important to sponsors and consumers, while keeping to the goal of a 15 to 20-minute interview. Sponsors typically were grateful they could rely on an external authority to maintain discipline over the content and length of the interviews. Although they identified some flawed questions and other needs for improvement, the sponsors generally perceived that the research, testing, and expertise that went into CAHPS went far beyond what they could have done on their own. They also valued the off-the-shelf products, consisting of the questionnaires as well as detailed instructions for sampling and data collection methods (Carman, et al., 1999).

The demonstrations revealed pervasive misunderstandings in the field about how surveys are conducted and how their results can be interpreted. Such misunderstandings contribute to distrust of survey-based plan performance information by many consumers and some individuals within sponsoring organizations. Consumers may be suspicious that the health plans have influenced the results, believe that the sample does not represent the health plan members, or believe that the individuals in the sample are not really like themselves (Du and Brown, 2001). There also are concerns that some CAHPS ratings measure physicians’ performance more than that of the health plan, or that the ratings conflicted with preconceived ideas. In the New Jersey Medicaid program, for example, some of the CAHPS ratings contradicted previous perceptions by some of the health benefits coordinators regarding the health plans (Farley, et al., 2002a). The coordinators expressed concern about the reports and ratings and preferred not to use them when working with beneficiaries who were choosing HMOs.

Several sponsors expressed concerns about the high costs of fielding a CAHPS survey, which derive from the requirement to have multiple within-plan survey samples to make plan comparisons. These costs are not affordable for many smaller organizations, so use of CAHPS

generally has been limited to large sponsors such as large private employers, Medicaid agencies, federal agencies (e.g., Medicare), and states as employers (Carman, et al., 1999). Efforts continue to reduce questionnaire length, but reduction in sample size also will decrease statistical power.

### **Reporting CAHPS Performance Comparisons**

Sponsors participating in the demonstrations, as well as other CAHPS users, varied widely regarding which CAHPS rating information they wished to provide to consumers and how they preferred to present it in comparative reports. There was little consensus about the “stars and bars” format, reference groups for comparisons of health plans, or standards for identifying significant differences in plan scores. Some sponsors and consumers liked the bar graphs that display the distribution of responses on a CAHPS measure; others preferred the stars that display summaries of relative performance, even though they tended to have trouble interpreting them correctly (Carman, et al., 1999). For example, both the Florida and New Jersey Medicaid programs used only the “stars” format to present comparative information on health plans’ CAHPS performance (Farley, et al., 2000; Farley, et al., 2002a). In Iowa, however, the Medicaid program used only the bars format, (Farley, et al., 2002b). They believed that the CAHPS stars would be misinterpreted because other rating systems (e.g., hotels) already use stars that are anchored in absolute values.

A majority of beneficiaries who received CAHPS reports reported they liked and used them (Short, et al, 2002). The reports also have been found to influence their knowledge, beliefs, and decisions (Hibbard, et al., 2002.) Paradoxically, beneficiaries with no previous experience with consumer assessment data who received a report indicated they were less confident in their choice of health plan than those who did not receive the CAHPS report. Beneficiaries who receive CAHPS for the first time may report less confidence because they find the decision more complex as a result of having more information than they had in the past, or alternatively, because the ratings of their own health plans did not conform to their prior perceptions.

To enhance the use of CAHPS reports by consumers, we learned that the CAHPS information should be distributed together with other enrollment information (McCormack, et al., 2000; Farley, et al., 2002a). If distributed separately, consumers may not associate the CAHPS report with their enrollment process (especially those not previously familiar with CAHPS), or they may complete enrollment before they receive the CAHPS report.

Both the contents of the CAHPS ratings and the format for presentation influence how consumers will use the ratings as they make health plan choices. A long report makes it difficult for consumers to find the ratings information quickly, thus discouraging them from using the report. The visual impact of the report also may attract or detract consumers from using it, or may lead users’ eyes to certain items on the report pages. There was strong consensus from the demonstrations that the first CAHPS report was too long. In response to this feedback, the CAHPS 2.0 survey contains fewer performance dimensions, and the report template is much shorter and in a format that is easier to read.

### **Consumer Use of the CAHPS Report**

Findings from the CAHPS demonstrations and laboratory studies suggest that privately insured consumers and Medicaid beneficiaries use plan performance information similarly (Short et al., 2002; Spranca et al., 2000). The laboratory experiments simulated health plan choices, in

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which privately insured and Medicaid consumers were asked to look at comparative CAHPS information on hypothetical health plans (along with other plan features), and were asked to choose among the health plan options. Participants were more likely to choose health plans that performed better on CAHPS according to the reports (Spranca et al., 2000; Kanouse et al., 2000). These laboratory experiments provided evidence of the efficacy of CAHPS plan performance information under controlled laboratory conditions. In the Medicaid laboratory experiment, Medicaid-eligible individuals also were willing to trade off valued benefits (dental or transportation) for plans with higher ratings (Kanouse et al., 2000).

The CAHPS report was found to be noticed most by consumers who were actually selecting a health insurance plan, that is, new enrollees, current enrollees who were switching plans voluntarily, or those whose current plan was no longer offered. Outcome evaluations found that reporting of CAHPS information to consumers influenced health plan choices only under certain circumstances, and the effect was small. In Harvard University's Washington state demonstration, consumers who could not stay with their old plan were more likely to choose highly rated plans than consumers who could stay in their existing plan (Guadagnoli, et al., 2002). RTI found small effects of some of the CAHPS dimensions on the health plan choices of employees of two firms (McCormack, et al., 2000). RAND also found a small effect of CAHPS on plan choice by Medicaid beneficiaries, as discussed below.

***New Jersey Medicaid Demonstration.*** The goal of the New Jersey Medicaid CAHPS demonstration was to assess the effects of CAHPS health plan performance information on plan choices and decision processes by Medicaid beneficiaries (Farley, et al., 2002a). The study sample was a statewide sample of all new cases in New Jersey Medicaid that chose health plans during April 1998. An experimental design was used such that new Medicaid cases were randomly assigned to experimental or control groups. The experimental group received a CAHPS report along with the standard enrollment materials, and the control group did not. We used HMO enrollment data obtained from the state in June 1998 for all the cases in this sample, and we also collected post-enrollment survey data for a subset of these cases from July to October 1998.

No effects of CAHPS information on HMO choices were found for the total sample. Further examination of survey data revealed that only about half the Medicaid cases said they received and read the plan report. There also was an HMO with dominant Medicaid market share but low CAHPS performance scores. The subset of cases who read the report and did not choose this dominant HMO were found to choose HMOs with higher CAHPS scores, on average, than did those in an equivalent control group. Thus, as intuition suggests, health plan performance information can influence plan choices by Medicaid beneficiaries only if they actually read it and if performance on CAHPS is more important than other health plan features. These findings suggest a need for enhancing dissemination of the information as well as further education to encourage informed choices.

***Iowa Medicaid Demonstration.*** Working in collaboration with the Iowa Medicaid program, RAND performed a second test of the effects of CAHPS information on health plan choices by Medicaid beneficiaries (Farley, et al., 2002b; Damiano, et al., 2002). The sample for this evaluation was all new cases entering Iowa Medicaid in selected counties during February through May 2000. These cases were assigned randomly to experimental or control groups for the study. The control group received standard Medicaid enrollment materials, and the experimental group received these materials plus a CAHPS report.

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When beneficiaries initially sign up for Iowa Medicaid, they are assigned to a default health plan and are informed what their default plan is. Thus, the plan choice made by beneficiaries in the Iowa Medicaid sample was a choice to switch plans, rather than the simple choice of a new health plan that the New Jersey Medicaid beneficiaries made.

We found that CAHPS information had no effect on decisions to switch from the default health plans by Iowa Medicaid beneficiaries. This result is similar to our null findings for the entire New Jersey Medicaid sample. We did not perform a survey of the beneficiaries in our Iowa Medicaid sample, so we could not identify those who reported noticing and using the CAHPS report for in-depth analysis.

### **Factors Contributing to Limited CAHPS Effects**

These results of weak CAHPS effectiveness in the field differ substantially from the observed effects on plan choice in the laboratory experiments, which tested CAHPS efficacy. It will be important to identify which factors might be contributing to its limited effects in the field, with the goal of increasing its effectiveness. Use of CAHPS report information is influenced by a variety of conditions (Short et al., 2002). For example, consumers must receive and notice the CAHPS report, and they must be able to easily understand the information it contains. Furthermore, they need to be receptive to the CAHPS information, which may include having a perceived need for the information, trusting its accuracy and objectivity, and viewing it as relevant to their unique health status or health care needs. A deficiency in any of these conditions is likely to diminish CAHPS impacts.

We know from survey responses in the New Jersey Medicaid evaluation that half of the Medicaid beneficiaries who were mailed CAHPS reports did not read them or even remember receiving them. This is consistent with findings from other CAHPS demonstrations that 24 to 77 percent of consumers receiving a CAHPS report looked at and remembered it (Berkman, et al., 2001; Short, et al., 2002). We expect that a similar issue occurred in the Iowa Medicaid evaluation, but without survey data, we could not estimate the proportion of Iowa beneficiaries who remembered using the report.

Our research suggests that noticing or using the report may not be the only factor attenuating CAHPS effects on plan choice in the field. For the subgroup of New Jersey Medicaid beneficiaries who had used the report, the CAHPS effect was much smaller than the effect observed in the Medicaid laboratory experiment that used hypothetical choices.

In Iowa, the new Medicaid beneficiaries were facing a form of switching decision because they knew which default plan they would be assigned to if they did not make another choice, even though they were not enrolled at the time. Previous research has found an inertia effect where consumers tend not to switch enrollments unless stimulated by a substantial change in the relative merits of the health plans available to them (Buchmueller and Feldstein, 1996; Buchmueller and Feldstein, 1997; Scanlon et al., 2002). It is difficult to predict inertia effects for new Medicaid enrollees. Inertia might not be found because most of our study population did not yet have experience as members of their default health plans, and they would give up little by choosing another option. On the other hand, they might be more willing to stay in a plan to which they were assigned because they had no prior knowledge about it, and they assumed the plan would serve them well unless they had a bad experience after enrolling.

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In theory, CAHPS information should serve as a useful tool to assist beneficiaries in making informed health plan choices as well as to inform quality assessment activities by survey sponsors. However, there is a growing body of evidence that the value of CAHPS reports in consumer decision making may be limited to the subset of consumers who actively study the information they are provided. Even for receptive consumers, the information may make a difference only when (1) there are large differences in ratings between plans, (2) the ratings are discordant with previously held beliefs about plan quality, and (3) the reports are easy to read and understand.

What remains to be seen is whether some of the conditions needed for Medicaid beneficiaries to use CAHPS reports will occur over time. This research on CAHPS effects was performed soon after the initial introduction of this new source of plan performance information. Consumers in both commercial and Medicaid insurance sectors were just beginning to learn how to use the information in making health plan choices; as they learn, larger percentages of them may notice and use it. At the same time, research is continuing with the goal of refining our ability to build and disseminate effective reports that are readily usable by the consumer.

### **NEW DIRECTIONS FOR CAHPS**

The second cycle of CAHPS (CAHPS 2) began in June 2002 with a consortium consisting of RAND, Harvard University, American Institutes for Research, and Westat working in collaboration with AHRQ. Building upon the achievements in the first CAHPS cycle (which we call CAHPS 1), the second cycle of is pursuing new pathways in several domains. These new efforts were identified from lessons learned during CAHPS 1, with the goal of continuing to improve existing products and to extend these scientifically grounded consumer assessment surveys and reports into other areas. Four key areas of work are summarized here.

***Evidence-based consumer reports.*** Substantial progress was made in CAHPS 1 on expanding the science of consumer reporting, but we also learned that each CAHPS sponsor had strong preferences regarding format for reporting the survey results (stars versus bars, other symbols) as well as overall design of the report document. For example, most Medicaid sponsors had little choice in the shape and size of the report because it had to fit in existing envelopes used to mail enrollment materials. Some sponsors preferred to include the CAHPS performance information as a component of a larger report, rather than use a separate document. We learned that we needed to systematically assemble evidence for many aspects of the CAHPS report design and dissemination. During the first year of CAHPS 2, we are gathering existing evidence from the relevant sciences—for example, cognition science, decision science, social psychology, social marketing, health education—and are performing a structured assessment of the evidence for the various aspects of reporting. Where science is found to be weak or missing, we are establishing a research agenda to be performed in the remaining years of CAHPS 2.

***Applications for quality improvement.*** We were reminded in CAHPS 1 that the health plans themselves, as well as provider groups providing care within these plans, are important stakeholders that clearly are affected by consumer assessment reports on the services they provide. The CAHPS consortium received frequent feedback from these stakeholders that the survey, as currently designed, does not give them actionable information they can apply in their quality improvement processes, to ultimately perform better on CAHPS measures. Therefore, in CAHPS 2 we are developing and assessing approaches and tools to make CAHPS information more useable for health plans and providers. This work will culminate in field demonstrations of



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quality improvement initiatives using the quality improvement tools developed. As a first step in this process, we are conducting market research interviews with health plans, provider groups, and a variety of other stakeholders. In these interviews we are seeking their views on the strengths and weaknesses of the current CAHPS products, issues to be addressed for consumer reporting and quality improvement, and suggestions for modifications.

***Three-level CAHPS survey.*** During CAHPS 1, work had begun on developing a CAHPS survey to obtain consumer assessments at the level of the provider group, with plans to extend that work to the individual provider level. This work continues in CAHPS 2, with the goal of establishing one survey instrument that encompasses questions applying to each of three levels—plan, provider group, and individual provider—and is designed so that survey data can be rolled up (or down) from one level to the next. This work involves not only development of an appropriate set of survey items, but also the specification of sampling frame, sampling strategy, data collection, and data file construction, so that survey results can be useful to the sponsors and technically valid. The stakeholder interviews identified above are identifying relevant issues and stakeholder preferences for this survey approach, as well as for applying a CAHPS survey at the group and provider levels.

***CAHPS in other populations or settings.*** Even as work continues on refining the core CAHPS products, sponsors have approached AHRQ for development of other products tailored to specific populations or settings of care. For example, CAHPS surveys and reports were developed for Medicare managed care and fee-for-service sectors during CAHPS 1. Work is underway in CAHPS 2 on products for hospital inpatient services, dialysis facility services to end-stage renal disease patients, services for persons with mobility limitations, services for American Indians, and nursing home care. The diversity of these applications suggests that CAHPS products also could be developed for workers' compensation medical care.

### **RELEVANCE FOR WORKERS' COMPENSATION MEDICAL CARE**

When considering the applicability of the CAHPS survey and report to workers' compensation medical care, the first step should be to examine these products in the context of the goals to be achieved in this setting. CAHPS was designed initially to provide comparative information for consumer choice of health plans, but increasingly it is being used for other applications, such as sponsors monitoring of health plan or provider quality, internal quality improvement activities, and payment policies that reward performance. The CAHPS survey is a scientifically tested and proven data collection instrument. Its usefulness to any given sponsor will be determined by its fit with the sponsor's goals.

In making this decision, a sponsor needs to determine how the CAHPS consumer assessment information would be used for workers' compensation medical care. Possible uses are to provide:

- Feedback to workers' compensation plans and providers on workers' views of their performance,
- Information to sponsors of the survey for use in selection and monitoring of workers' compensation plans and providers,
- Information to workers for choice of a workers' compensation plan or provider,

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- Comparisons of the performance of a given set of workers' compensation plans and provider to benchmarks of performance of similar groups on a larger scale.

A sponsor could pursue one or all of these uses, or others not listed here. The first two of these applications—feedback to plans and providers and information for sponsors—will be relevant regardless of the design of a state's workers' compensation program. The third application will be relevant only if workers have a choice of plans or providers. The use of benchmark comparisons will be feasible only if a sponsor has CAHPS data (or data from any other standard survey) for a large number of plans or providers that can be used to develop the benchmarks. On a larger scale, if multiple sponsors use the survey, the benchmarking opportunities become richer.

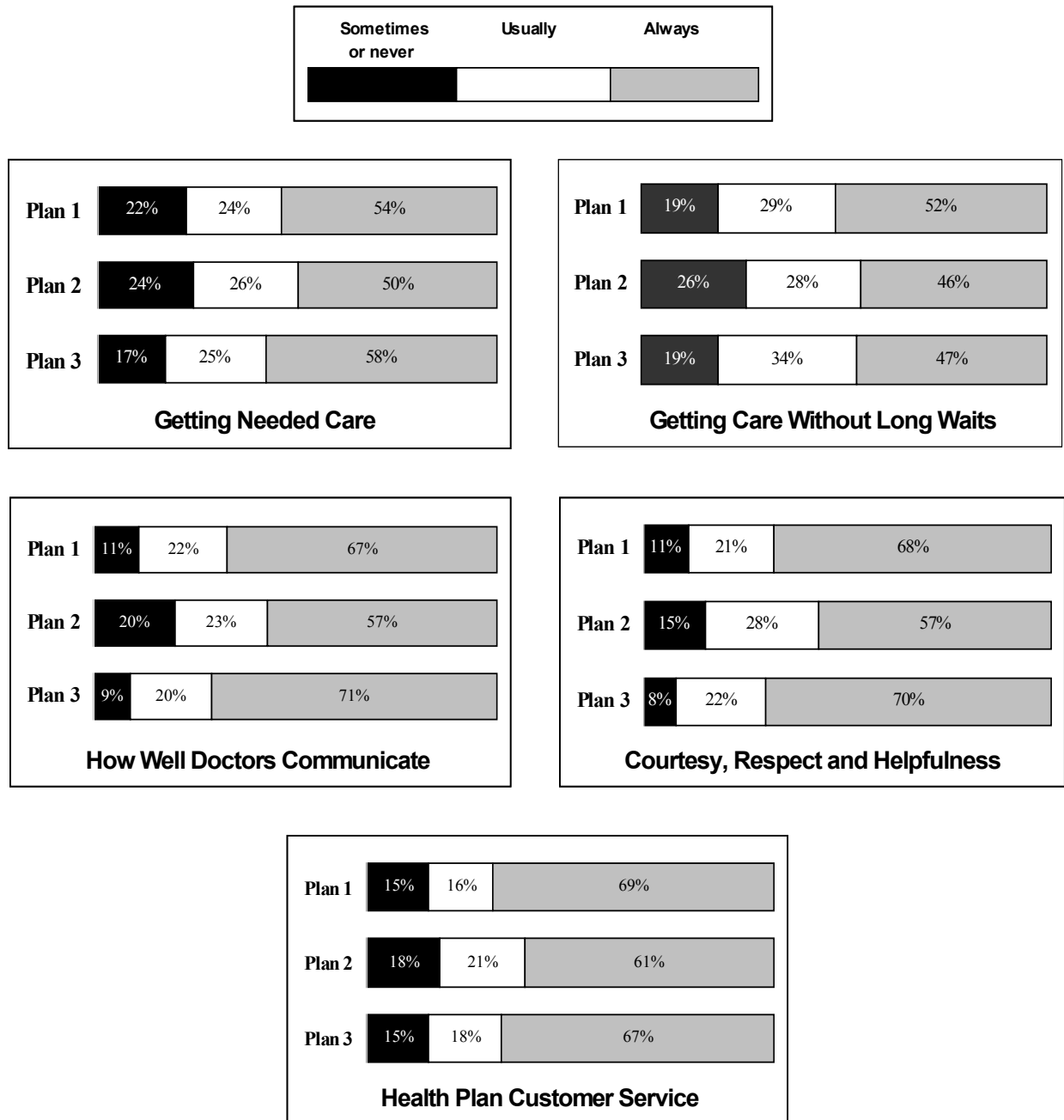
When developing a CAHPS survey for workers' compensation medical care, a key question to be addressed is, "What is the important information to be collected?" The answer to this question should be driven by the information needs of the users, which in turn are driven by how the survey results will be used. The answer to these questions also will guide decisions on sampling strategy and reporting.

The same principles that guided the development of the existing CAHPS surveys should also guide survey design for workers' compensation medical care. These include use of focus groups to identify topics of importance to workers, cognitive testing of new survey items, and psychometric testing of the items in survey pilot tests. Careful attention to technical integrity will ensure that sponsors are using a scientifically sound questionnaire that yields reliable and valid information, regardless of the mode of survey administration. In this process, a balance must be sought among validity, statistical power to interpret results, respondent burden, and costs of survey administration.

**Figure 1. Star Displays of CAHPS Measures for the New Jersey Medicaid Health Plans**

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Plan 9	Plan 10
Overall rating of health plan	★ ★	★	★ ★	★ ★ ★	★ ★	★ ★	★ ★	★	★ ★ ★	★ ★ ★
Overall rating of quality of care	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★	★ ★	★ ★	★ ★ ★
Overall rating of doctor (or nurse)	★ ★	★ ★	★ ★	★ ★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★
Easy to find a personal doctor (or nurse) you are happy with	★	★ ★	★ ★	★ ★	★ ★	★ ★	★	★ ★	★ ★	★ ★
Getting the care you need	★ ★	★	★ ★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★
Getting care without long waits	★	★ ★	★ ★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★
Easy to get referrals to specialists	★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★ ★
Doctors (or nurses) who communicate well with patients	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★	★ ★	★ ★	★ ★ ★
Doctors (or nurses) who spend enough time with their patients and know their medical history	★ ★	★ ★	★ ★	★ ★	★ ★	★ ★	★	★ ★	★ ★	★ ★ ★
Being encouraged to exercise or eat a healthy diet	★ ★	★	★ ★	★ ★	★ ★ ★	★ ★	★ ★	★ ★	★ ★ ★	★ ★
<b>Did this Plan do well on the things that are important to you?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Figure 2. Bar Displays of CAHPS Measures for the Iowa Medicaid Health Plans**



## **Appendix A**

### **CAHPS® 2.0 REPORTING COMPOSITES**

#### **Adult Survey Composites and Items Response format**

Listed on the AHRQ web site at [www.ahrq.gov/qual/cahps/composit.htm](http://www.ahrq.gov/qual/cahps/composit.htm)

#### **GLOBAL RATINGS:**

##### ***People's ratings of their care***

Q31-Use any number on a scale from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate all your health care?

0-10 Scale

##### ***People's ratings of their health plan***

Q38- Use any number on a scale from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate your health plan now?

0-10 Scale

#### **REPORT COMPOSITES:**

##### **Getting Care**

##### ***People's experiences in getting care they need***

Q6-With the choices your health plan gives you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

A big problem, A small problem, Not a problem

Q10-In the last 12 months, how much of a problem, if any was it to get a referral to a specialist that you needed to see?

A big problem, A small problem, Not a problem

Q22-In the last 12 months, how much of a problem, if any, was it to get the care you or your doctor believed necessary?

A big problem, A small problem, Not a problem

Q23-In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?

A big problem, A small problem, Not a problem

***People's experiences in getting care quickly***

Q15-In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?

Never, Sometimes, Usually, Always

Q17-In the last 12 months, how often did you get an appointment for regular or routine health care as soon as you wanted?

Never, Sometimes, Usually, Always

Q19-In the last 12 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?

Never, Sometimes, Usually, Always

Q24- In the last 12 months, how often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time to see the person you went to see?

Never, Sometimes, Usually, Always

**Doctor's and Medical Care**

***People's experiences with how well their doctors communicate***

Q27- In the last 12 months, how often did doctors or other health providers listen carefully to you?

Never, Sometimes, Usually, Always

Q28-In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?

Never, Sometimes, Usually, Always

Q29-In the last 12 months, how often did doctors or other health providers show respect for what you had to say?

Never, Sometimes, Usually, Always

Q30-In the last 12 months, how often did doctors or their health providers spend enough time with you?

Never, Sometimes, Usually, Always

## **Medical Office Staff**

### ***People's experiences with courtesy, respect, and helpfulness of office staff***

Q25-In the last 12 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?

Never, Sometimes, Usually, Always

Q26-In the last 12 months, how often were office staff at a doctor's office or clinic as helpful as you thought they should be?

Never, Sometimes, Usually, Always

## **The Health Plan**

### ***People's experiences with health plan customer service, information, paperwork***

Q33-In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?

A big problem, A small problem, Not a problem

Q35-In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?

A big problem, A small problem, Not a problem

Q37-In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?

A big problem, A small problem, Not a problem

## REFERENCES

- Agency for Healthcare Research and Quality. 1999. CAHPS® 2.0 Survey and Reporting Kit. AHRQ Publication No. 99-039.
- Berkman N, M Kuo M, C Wiesen. 2001. The Impact of CAHPS Survey Data on Two Employed Populations, *Abstract Book of the AHSRHP Annual Meeting* 18:167.
- Brown JA, SE Naderend, RD Hays, PF Short, and DO Farley. March 1999. Special Issues in Assessing Care of Medicaid Recipients, *Medical Care* 37(3):MS79-MS88 *Supplement*.
- Buchmueller, TC, and PJ Feldstein. 1996. Consumers' Sensitivity to Health Plan Premiums: Evidence from a Natural Experiment in California. *Health Affairs* 15(1):143-151.
- Buchmueller, TC, and PJ Feldstein. 1997. The Effect of Price on Switching Among Health Plans. *Journal of Health Economics* 16:231-247.
- Carman K, PF Short, DO Farley, et al. March 1999. Epilogue: Early Lessons from CAHPS Demonstrations and Evaluations, *Medical Care* 37(3):MS97-MS105 *Supplement*.
- Castles, A, P Goodwin, and C Damberg. 1997. "Consumer Use of Quality of Care Information: An Evaluation of California Consumer HealthScope." *Abstract Book of the Association of Health Services Research*. Washington, DC: Association for Health Services Research Vol. 14: 171-2.
- Chernew, M, and DP Scanlon. 1998. "Health Plan Report Cards and Insurance Choice." *Inquiry* 35 no. 1 (spring): 9-22.
- Crofton, C, J Lubalin, and CS Darby 1999. "Foreword." *Medical Care* (Supplement) 37 no 3 (March): MS1-MS9.
- Damiano, PC, JC Willard,, MC Tyler, ET Momany, RD Hays, DE Kanouse, and DO Farley. 2002. CAHPS® in practice: The Iowa demonstration, *Journal of Ambulatory Care Management* 25:32-42.)
- Davis, K, KS Collins, C Schoen, and C Morris. 1995. "Choice Matters: Enrollees' Views of their Health Plans." *Health Affairs* 14 no. 2 (summer): 99-112.
- Du, C, and JA Brown. 2001. Feedback from Beneficiaries on the Iowa Medicaid CAHPS® Report, RAND/DRU 2560-AHRQ.
- Farley DO, ME Elliott, PF Short, DE Kanouse, RD Hays. September 2002b. Effects of CAHPS® Health Plan Performance Information on Health Plan Choices by Iowa Medicaid Beneficiaries, *Medical Care Research and Review*, 59(3):319-336.
- Farley DO, PF Short, MN Elliott, DE Kanouse, JA Brown, RD Hays. August 2002a. Effects of CAHPS® Health Plan Performance Information on Plan Choices by New Jersey Medicaid Beneficiaries, *Health Services Research*, 37(4):985-1008.
- Farley DO, PF Short, DE Kanouse, D Schoeff, JA Brown, M Spranca, RD Hays. March 2000. *Testing CAHPS Health Plan Performance Reports in the Florida Medicaid Program*, RAND/MR-1218-AHRQ.



- Fowler, F. J., PM Gallagher, and S Nederend. 1999. "Comparing Telephone and Mail Responses to the CAHPS Survey Instrument." *Medical Care* (Supplement) 37 no 3 (March): MS41-MS49.
- Gibbs, DA, JA Sangl, and B Burrus. 1996. "Consumer Perspectives on Information Needs for Health Plan Choice." *Health Care Financing Review* 18 no. 1 (fall): 31-54.
- Guadagnoli, E; AM Epstein, A Zaslavsky, JA Shaul, D Veroff, FJ Fowler, Jr, PD Cleary, P D. July 2002. Providing Consumers with Information About the Quality of Health Plans: the Consumer Assessment of Health Plans Demonstration in Washington State, *Joint Commission Journal of Quality Improvement* 26(7):410-20.
- Harris-Kojetin, LD, FJ Fowler, JA Brown, JA Schnaier, and SF Sweeny. 1999. The Use of Cognitive Testing to Develop and Evaluate CAHPS® 1.0 Core Survey Items, *Medical Care* (Supplement) 37 no 3 (March): MS10-MS21.
- Hays, RD, JA Shaul, VSL Williams, JS Lubalin, LD Harris-Kojetin, SF Sweeny, and PD Cleary. 1999. Psychometric Properties of the CAHPS® 1.0 Survey Measures, *Medical Care* (Supplement) 37 no 3 (March): MS22-MS31.
- Hibbard, JH; N Berkman, LA McCormack, E Jael. March 2002. The impact of a CAHPS report on employee knowledge, beliefs, and decisions, *Medical Care Research and Review* 59(1):104-16.
- Hibbard, JH, L Harris-Kotejin, P Mullin, J Lubalin, and S Garfinkel. 2000. Increasing the Impact of Health Plan Report Cards by Addressing Consumers' Concerns. *Health Affairs* 19(5):138-143.
- Kanouse, DE, ME Spranca, J Uhrig, MN Elliott, PF Short, DO Farley, and RD Hays. 2000. "Effects of CAHPS Reports on Medicaid Recipients' Choice of Health Plans in a Laboratory Setting." Paper presented at the meeting of the *Association for Health Services Research*, Los Angeles, CA.
- Knutson, DJ, N Dahms, E Kind, J McGee, M Finch, and JB Fowles. 1997. "The Effect of Health Plan Report Cards on Consumer Knowledge, Attitudes and Plan Choice: A Quasi-Experimental Evaluation." *Abstracts of the Association of Health Service Research*. Washington, DC: Association of Health Services Research. Vol 14: 184.
- Marquis, MS, and JA Rogowski. 1991. *Participation in Alternative Health Plans*. RAND/R-4105-HCFA, Santa Monica: RAND.
- Marshall GN, LS Morales, M Elliott, K Spritzer, RD Hays. June 2001. Confirmatory factor analysis of the Consumer Assessment of Health Plans Study (CAHPS) 1.0 Core Survey *Psychological Assessment* 13(2):216-29.
- Marshall MN, PG Shekelle, and RH Brook. 2000. "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence." *Journal of the AMA* 283 no.14 (April 12):1866-74.
- McCormack LA, ND Berkman, TM Kuo, JH Hibbard, SA Garfinkel, SE Daugherty. 2000. The Effect of Quality of Care Information on the Probability of Switching Health Plans, *Abstract Book of the AHSRHP Annual Meeting* 17.

- Mechanic, D, T Ettel, and D Davis. 1990. "Choosing Among Health Insurance Options: A Study of New Employees." *Inquiry* 27 (Spring) :14-23.
- Robinson, S, and M Brodie. 1997. "Understanding the Quality Challenge for Health Consumers: The Kaiser/AHCPR Survey." *Joint Commission Journal on Quality Improvement* 23 no 5 (May): 239-44.
- Sainfort, F, and BC Booske. 1996. "Role of Information in Consumer Selection of Health Plans." *Health Care Financing Review* 18 no. 1 (fall): 31-54.
- Scanlon, DP, M Chernew, and JR Lave. 1997. "Consumer Health Plan Choice: Current Knowledge and Future Directions." *Annual Review of Public Health* 18 507-28.
- Scanlon, DP, M Chernow, C McLaughlin, and G Solon. 2002. The Impact of Health Plan Report Cards on Managed Care Enrollment. *Journal of Health Economics* 754:1-23.
- Short, PF, L McCormack, J Hibbard, JA Shaul, L Harris-Kojetin, M Fox, P Damiano, JD Uhrig, PD Cleary. April 2002. Similarities and Differences in Choosing Health Plans. *Medical Care* 40(4):1-14.
- Solomon, LS; AM Zaslavsky, BE Landon, PD Cleary. Summer 2002. Variation in patient-reported quality among health care organizations, *Health Care Financing Review* 23(4):85-100.
- Spranca, ME, DE Kanouse, PF Short, DO Farley, and RD Hays. 2000. "Do Consumer Reports of Health Plan Quality Affect Health Plan Selection?" *Health Services Research* 35 (5, Part I), 933-947.
- Tumlinson, A, A Hendricks, EM Stone, P Mahoney, and H Bottigheimer. 1997. "Choosing a Health Plan: What Information Will Consumers Use?" *Health Affairs* 16 no. 3 (May-June): 229-38.
- Zaslavsky AM, LB Zaborski, PD Cleary. June 2002. Factors affecting response rates to the Consumer Assessment of Health Plans Study survey. *Medical Care* 40(6):485-99.
- Zhan C, J Sangl, GS Meyer, AM Zaslavsky. February 2002. Consumer assessments of care for children and adults in health plans: how do they compare?. *Medical Care* 40(2):145-54.